

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005086</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/03/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MAJOR HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>150 W WASHINGTON ST SHELBYVILLE, IN 46176</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 33212 Facility Number: 005086</p> <p>Type of Survey: State Licensure Off Site HFAP Accreditation Survey</p> <p>Date of HFAP On Site Survey - Hospital full survey 3-31thru4-3/2014 Date of ISDH off site review -6/272014</p> <p>Reviewer/Surveyor Nancy Otten RN, PHNS</p> <p>Based on review of the April 3, 2014 HFAP Accreditation Survey Report, it has been determined that Major Hospital meets the requirements for Hospital Licensure in Indiana for 2014.</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE